BARRIERS TO HEALTH INSURANCE SERVICES UPTAKE IN THE INFORMAL SECTOR IN KAMPALA, CENTRAL DIVISION

BY

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ABBREVIATIONS

HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
NHIS	National Health Insurance Services
SHI	Social Health Insurance
USAID	United States Agency for International Development
UHC	Universal Healthcare Coverage
WHO	World Health Organization

ABSTRACT

Health insurance services have been proposed as one of the strategies to protect the insured client from out of pocket payments that continue to hinder millions of people from accessing healthcare services. Out of pocket payments not only hinder access to healthcare but also caused financial catastrophe to some families and individuals as theystrive to access the much needed healthcare. Despite the potential benefits and the availability of health insurance services in Uganda, the uptake of the services in still limited, particularly in the informal sector that compromises the biggest part of the population.

The purpose of this research was to examine the relationship between knowledge, attitude, and financial barriers and the uptake of health insurance services in the informal sector in Central division, Kampala City. The study was guided by the following specific objectives: a) To analyze the relationship between knowledge barriers and health insurance services uptake in the informal sector. b) To examine the relationship between attitude barriers and health insurance services uptake in the informal sector. c) To analyze the relationship between financial barriers and health insurance services uptake in the informal sector.

The study adopted a case study design, incorporating both qualitative and quantitative approaches. The data collection tool was a questionnaire with both quantitative and qualitative items. The study used purposive followed by simple random selection to obtain 175 respondents in the informal sector in Central Division. Of these, 137respondents returned fully filled questionnaires.

The data obtained was analyzed using Statistical Package for the Social Sciences (SPSS). Quantitative data was analyzed using descriptive statistics of frequencies, percentages and mean. Qualitative data was presented thematically as quotations.

The study found out that there was a positive strong correlation between knowledge barriers and the uptake of health insurance services, $r(135) = .0773$, $p \leq 0.00$.

There is a positive correlation between financial barriers and the uptake of health insurance services, $r(135) = 0.473$, $p \leq 0.00$

A multiple regression analysis showed that knowledge, attitude and financial barriers explain 63.4%, R square = .643. Knowledge and financial barriers are influential predictors of uptake of health insurance services. (Beta = .602, t-test = 7.530), (Beta = .220, t-test = 3.940) respectively. Attitude barriers were not an influential predictor of health insurance services uptake. (Beta = .116)

The study concluded that the uptake of health insurance services is negatively affected by knowledge gaps, and the uncertain financial situation of the informal sector.

The study recommends that the key stakeholders should improve the flow of information to the informal sector to cover the knowledge gaps as one of the strategies to improve health insurance services uptake. Insurance companies should also provide flexible premium payment terms to suit the informal sector.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

Healthcare costs continue to escalate, pushing families and individuals into huge spending to access the much needed care. According to World health Organization, every year 100 million people are pushed into poverty and 150 million people globally suffer financial catastrophe because of out-of-pocket expenditure on health services. It's against this background that the World Health Organization recommends the Universal Health Care coverage (UHC) as a model to provide quality, accessible health care to the populations.

Universal health coverage aims to ensure that everyone, everywhere, can access quality health services without facing financial hardship as a result. Financial protection is at the core of UHC and improving financial protection is a central focus of health financing policies. One key strategy to implement UHC is through accessing functional health insurance services.

Health insurance schemes have therefore been proposed as one of the useful strategies for mobilizing resources for health, pooling risks, providing equitable healthcare and delivering improved healthcare (Carrin *et al*, 2008).Health insurance packages are designed to provide the economic incentive of financial protection to the insured individuals and alsoto help the nations in healthcare planning and financing. Health insurance is an agreement between a beneficiary or policy holder and an insurance organization to protect the beneficiary from paying catastrophic medical costs in case of illness or injury.

This study examines the relationship between knowledge barriers, attitude barriers and financial barriers to the uptake of health insurance services to the informal sector in Central division, Kampala city. This chapter presents the background to the study, problem statement, purpose of the study, objectives of the study, study questions, conceptual framework, and scope of the study, justification, significance, and operational definition of terms.

1.1 Background to the study

Health insurance began in the United States over two centuries ago when Citizen Groups were organizing workers and the unemployed, veterans, the elderly, and others calling for government relief, including government-sponsored health protection. In his first term, President Roosevelt appointed a committee on economic security which was to report with a program that addressed old-age and unemployment issues, as well as medical care and health insurance in 1934 (Roy, 2008). As late as 1910, the cost of health care treatment was considered a major problem compared to the loss of wages due to sickness for most workers. In the early 1900s, patient care was largely limited to preventing disease by keeping clean, recommending good diets, providing good nursing care, performing basic surgery, and praying for a rapid recovery (Joseph and Ross, 2002).

In sub-Saharan Africa, the situation of the health scheme in both formal and informal sectors is characterized by inadequate budget allocation to the health sector coupled with financial barriers to use resulting from out-of-pocket fees; and inadequacies of physical input and human resources resulting in poor quality of health care (Vogel, 2010).

Social health insurance first began in Uganda in 1987, when it was recommended by the Health Policy Review Commission. Having noted that the health sector was inadequately financed, the

Commission listed, among other alternatives, the introduction of Social Health Insurance as a means of generating additional funding for the health sector. Due to severe budget constraints and related difficulties in providing adequate hospital services, community health insurance or pre-payment schemes were introduced at some hospitals as a means of collecting additional funds. This led to the establishment of eight hospital-based community prepayment schemes (Zikusooka and Kyomuhangi, 2008).

In 2014, there were 16licensed insurance companies in the country that offered the health insurance component (Uganda Insurance Commission, 2014). In addition to standard health insurance firms, there are health maintenance organizations (HMO) that offer medical pre-payment schemes. In Uganda, health insurance organizations are involved in collecting insurance premiums from either individuals or companies in return for specified health benefit packages for those who are covered by insurance.

Health insurance is insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care and health system expenses, among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity. (Asfaw and von Braun, 2005).

Access to affordable and effective health care is a major problem in low and middle income countries (McIntyre *et al.* 2006; Van Doorslaer *et al.* 2006). One way to facilitate access and overcome huge expenditure is through a health insurance mechanism, whereby risks are shared and financial inputs pooled by way of contributions from salaries or taxation (Carrin *et al.* 2005).

Many developing countries face the challenge of extending health insurance coverage to the informal sector. It is estimated that every year more than 44 million households face financial ruin because of direct health care expenditure (De-Allegri *et al* 2009).User fees constitute a major part of such expenditures. As a consequence, user fees have been, and still are, a major contributing factor to the high incidence of out-off pocket payment by individuals and households at the time of illness (Bennet and Monasch, 2007).

Health insurance for the informal sector still remains a big challenge as most private health insurance service providers ask for big premiums which most people in the informal sector may not afford. Private insurance companies tend to design policies with the aim of attracting people with lower-than-average health risks and exclude those with higher health risks a practice commonly known as cream-skimming (Chuma *et al,* 2013). This can lead to discrimination and the exclusion of specific groups including women, elderly people, and people living with chronic conditions such as diabetes, hypertension and HIV.

It is against this background that the study sought to examine those barriers that affect the uptake of health insurance services in the private sector business persons in Central Division, Kampala City.

The study was conducted among informal businesses that ply their trades on four streets of central division: Luwum Street, Ben Kiwanuka Street, Market Street and Kikuubo Lane. These streets are located in a busy business hub with a wide range of business operations.

1.2 Statement of the Problem

Out of pocket expenditure for health continues to increase amidst government provision of free health services in government health facilities. Twenty eight percent (28%) of the households in Uganda are experiencing catastrophic payments to access healthcare services (World Bank,

2010). Percentage of households incurring catastrophic health expenditure in Uganda increased from 8% to 28% between 1996 and 2006, despite the elimination of user fees in 2001. Up to 2.3% households were pushed into impoverishment because of medical bills over the same time period. Private health insurance, which is largely subsidized by formal sector employers for their employees, covers only 0.2% of the Ugandan population (WHO, 2010).

However, the informal sector is still not largely covered as most still use off-pocket medical cost covering method. According to USAID (2013),less than 10% of the informal sector people in urban areas take up individual health insurance packages, consider health insurance very expensive and for only the rich or those with formal employment. Further still, very few know about health insurance and its benefits, leading to low demand for health insurance services among the informal sector, others have negative attitude towards health insurance, while others do not trust the system of health insurance packages to deliver as expected. Other would be clients fear the bureaucracy that is involved in the process of accessing health services after subscribing to the scheme (USAID, 2013). The study therefore analyzed the barriers and their relationship to the uptake of health insurance services in the informal sector, using central division, Kampala as a case study.

1.3 Objectives of the study

The study was guided by the following objectives:

1.3.1 Major objective of the study

The study examined the barriers and their relationship to health insurance services uptake in the informal sector in the Central Division of Kampala City.

1.3.2 Specific objectives of the study

a) To analyze the relationship between knowledge barriers and health insurance services uptake in the informal sector in Central division, Kampala.
b) To examine the relationship between attitude barriers and health insurance services uptake in the informal sector in Central division, Kampala
c) To analyze the relationship between financial barriers and health insurance services uptake in the informal sector in Central division, Kampala.

1.3.3 Research questions

a) How do knowledge barriers hinder health insurance services uptake in the informal sector in Central division, Kampala?
b) How do attitude barriers affect health insurance services uptake in the informal sector in Central Division, Kampala?
c) How do financial barriers affect health insurance services uptake in the informal sector in Central Division, Kampala?

1.4 Conceptual Frame work

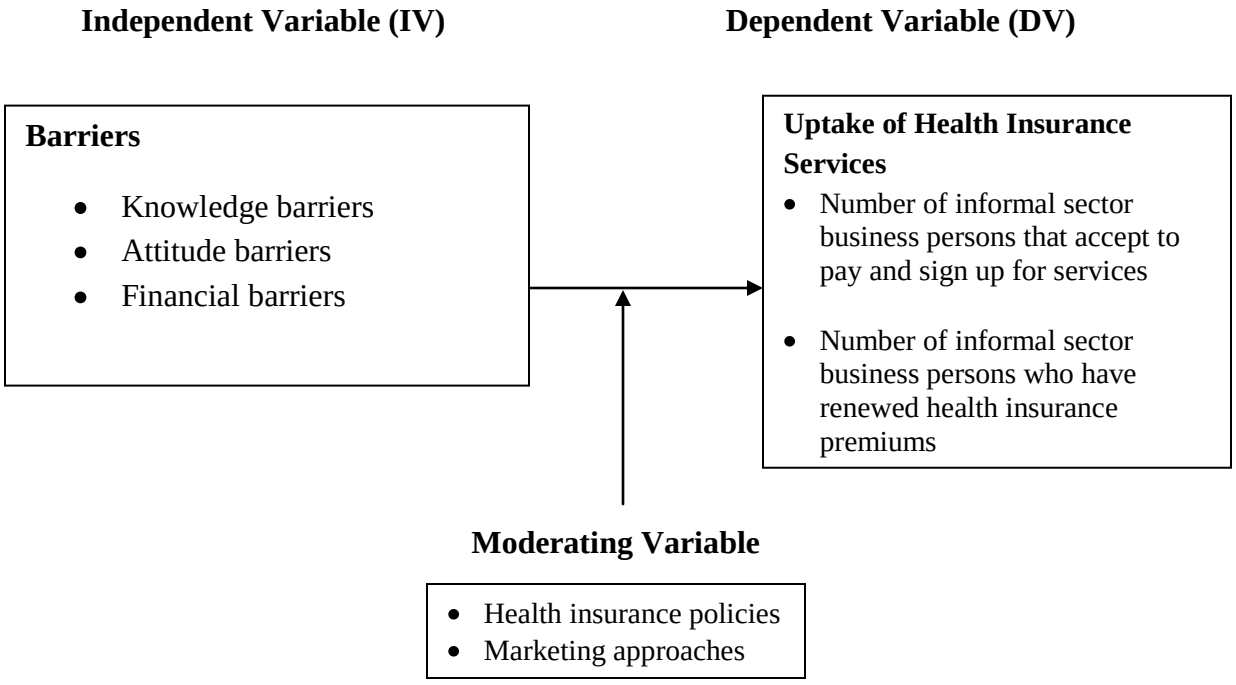

Figure 1: Conceptual framework. Source: Developed by the researcher as guided by Sinha *et al* (2006).

The framework shows the relationship between the independent variables and the dependent variable. The independent variables in this study are knowledge, attitude and financial barriers, while the dependent variable is the uptake of health insurance services in the informal sector.

1.5 Justification for the study

Health insurance is a crucial aspect in every one's life, especially among the people in informal sector or the business environment where financial stability is very unpredictable. Health insurance comes in various packages designed for different individual preferences. Convincing a private business person to take up health insurance is however still a difficult task as they don't see any immediate returns and consider it a government responsibility or a practice for those in

the formal sector. This study is justified under the ministry of health and other agencies in their efforts to ensure that every Ugandan can get access to health facilities through a well-planned and managed health insurance scheme. This research will help in drafting of policies and other guidelines that will guide the establishment of viable health insurance schemes and to streamline the delivery of health insurance services to the majority of the Ugandan population, especially the informal sector that forms the bulk of the population.

The issue of health insurance among Ugandans has not been taken seriously especially among the informal sector business persons who see it an unnecessary expense.

It is in this regard the study sought to examine the relationship between barriers and the uptake of health insurance among the informal sector focusing on Central Division, Kampala City.

1.6 Significance of the Study

The results of the study will be valuable to;

The informal sector business persons: The information gathered in this study will be used to inform the people in the informal sector who may not have realized the importance of health insurance to thoroughly understand it and be able to utilize it especially where there is financial instability in and uncertainties in health status and healthcare. This will be done basing on the recommendations that will be made in this study. Implementation of the recommendations will introduce health insurance services to the informal sector business persons and is hoped to eventually help improve the uptake health insurance.

Policy makers: For individuals charged with formulating policies, their understanding of the key factors that influence the uptake of health insurance remains very vital if viable health insurance policies are to be initiated and managed. Findings of this study will provide the information

necessary for the policy makers to formulate better strategic policies so as to improve the uptake of health insurance especially among informal business communities.

Researchers: The issues raised in this study are likely to lead to the involvement of various researchers in generating more knowledge on health insurance and its significance in securing financial protection in uncertain health conditions. The findings of this study could form a basis for further research to those interested in health insurance and how well it can be improved.

1.7 Scope of the study

1.7.1 Content Scope

The study examined the relationship of knowledge, attitude and financial barriers to the uptake health insurance in the informal sector in Central Division, Kampala District.

1.7.2 Geographical scope

The study was carried out in the Central Division of Kampala District. This division was selected because it has a high concentration of informal businesses presumably with resources and capacity to take on health insurance services.

1.7.3 Time scope

The study considered a period from 2014 to the start of 2016. This time enabled the researcher to write the proposal, obtain all necessary approvals for the study, collect data, conduct data analysis and compile the final research report.

1.8 Operational Definitions of key terms

Barrier: Any condition that makes it difficult to make progress or to achieve an objective. In this case, a barrier is considered as any condition that will make uptake of the available health insurance services difficult or not possible.

Health insurance: This is the protection against the unexpected future expense of medical care. The insurance cover then entitles a package of pre agreed services to the client from the health service provider. The insurance companies then reimburse the costs to the health service provider.

Health insurance is defined as coverage that provides for the payments of medical costs as a result of sickness or injury.

Uptake: The client receives information about a service and accepts to purchase and take it up or sign up for it.

Informal sector: The urban informal sector in Uganda consists of all economic activities outside the formal institutional framework. Trade is by far the most important activity with 72% of the informal sector employment, manufacturing 23% and services 6%.

1.9 Conclusion

This research report has five chapters. Chapter one covers the general introduction which entails the background to the study, problem statement, the general and specific objectives of the study, the research questions, conceptual framework, the scope, significance of the study, and operational definitions of key word or terms. Chapter two covers the literature review, involving both the theoretical and empirical literature review. Chapter three provides the research design, area of study, study population, sample size and selection techniques, data types and collection methods and instruments. It further shows the validity and reliability aspects, data analysis, model specification and estimation and ethical consideration, chapter four presents, analyses and discuses findings. Chapter five summarizes, concludes and provides recommendations for the study.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The main objective of this chapter is to review literature related to barriers to uptake of health insurance services in the informal sector. This chapter will begin with the theoretical reviews related to health insurance uptake. This will be followed by discussion of the literature related to knowledge, attitude and financial barriers to the uptake of health insurance services in the informal sector.

2.1 Theoretical review

Various theories have been advanced by different scholars to explain the uptake of health insurance. These include;

2.1.1 The expected utility theory

The study adopted this theory advanced by Davis *et al*, (1997) which states that insurance demand is a choice between an uncertain loss that occurs with a probability when uninsured and a certain loss like paying a premium. Expected utility theory assumes that people are risk averse implying that the more risk averse individuals are, the more insurance coverage they will buy.

This suggests that consumers' utility level and tastes are influenced by their state, such as health or socio-economic status. Accordingly, people may have different degrees of risk aversion, which can influence their insurance decision. For example, Individuals who perceive their health status as very good may be less likely to enroll than individuals who perceive their health status

as less than optimal. Households with higher socio-economic status are in a good position to afford (paying premium) or may have better understanding of the benefits of being insured.

In the utility theory, people choose to insure if expected utility under the scheme is larger than expected utility without being enrolled into the scheme. Next to the price, the expected utility of the scheme is formed by risk preference and believes over future health costs depending on valuations of own health, and health risks. The demand for health insurance arises from individuals who prefer certainty or wealth security to uncertainty and risk. Adverse selection, taking place in the context of uncertainty, arises from asymmetric information, where the principal knows his risk profile and the insurer does not. Adverse selection can be counterbalanced by enhancing enrollment among more risk-averse types who behave more cautiously compared to less risk adverse types (Weinstein, 2009). Cautiousness could display for example in taking less health risks, engaging less in risky situations and doing more on illness prevention, all three possibly leading to better health and lower health care consumption.

The study also looked at a closely related the consumer demand theory for health insurance. (Nyman, 2003) suggests that consumers who voluntarily purchase unsubsidized health insurance are better off. Poor individuals will insure if they perceive the benefits of insurance as high than the cost related to giving up being uninsured.

2.1.2 The diffusion Theory

This theory advanced by Lionberger (1960) stipulates that people process and accept information by going through five stages which is not done impulsively. The stages include; awareness stage where the individual is exposed to the idea but lacks knowledge of its benefit the interest stage is when the idea arouses the individual who assess the possibility of using it, evaluation stage where the individual must consider whether the idea is potentially useful and of benefit to them,

trial stage is when the individual tries out the idea on himself and others in order to conclude how he can benefit. Adoption stage represents final acceptance of the idea and using it consistently based on continuous satisfaction.

2.1.3 Social exchange theory

This theory advanced by Thibaut and Kelley (1959) uses the economic metaphor of cost and benefits to predict behavior. The theory assumes that individuals and groups choose strategies based on perceived rewards and costs, where they factor in the consequences of their behavior before acting in order to keep their costs low and rewards high.

2.1.4 Conventional health insurance theory

Conventional theory, developed by Pauly (1968) holds that moral hazard, the additional health care purchased as a result of becoming insured is an opportunistic price response and is welfare decreasing since the value of additional healthcare purchased is less than it costs.

The difference between the high costs of the resources used to produce this care is reflected in high market price and its low apparent value to insured consumers as reflected in low insurance price and this represents inefficiency. The theory provided an apparent policy solution to this moral hazard by imposing coinsurance payments, deductibles and capitations to increase the price of medical care to insured customers and reduce the inefficient expenditures.

The above discussion of the theories related to health insurance uptake reveals the several factors that influence the uptake of health insurance services. This study considered barriers related to knowledge, attitude and finance.

2.2 Knowledge barriers to uptake of health insurance

Health insurance operates by risk-pooling, financed through regular premiums and tailored to poor people who would otherwise not be able to take out large scale insurance (Hsiao *et al,* 2004). Community based insurances though with problems relating to the extent of resource pooling, has however been shown to facilitate and improve access to health care services especially among children and pregnant women.

There are several types of health insurance. Mandatory is often called national or social health insurance, which may be used interchangeably, is a compulsory type of health insurance. This type of insurance requires by law that certain groups or the entire population is covered. National health insurance is a form of mandatory health insurance that covers the whole population including those who have not contributed to the scheme. Social health insurance on the other hand is for specific group of people lawfully permitted to become members or strictly those who make contribution to the scheme are entitled to coverage (Palmer*et al,* 2004).

Ombeline and Gelade (2012) reviewed the demand of health insurance in low income countries and observed that the concept of spending funds in anticipation of a future payout was relatively new in low income countries. Intensive insurance literacy targeting the informal sector would be needed to address this challenge.

Platteau and Ontiveros (2013) studied the factors underlying low uptake and renewal rates of health insurance services in India and noted that insufficient information led to low enrolment and renewal of the premiums. They further noted that when enrolled members received benefits that were considered lower than the premiums paid, they were less likely to renew the insurance premium. The study recommended a need for continuous communication and the physical

presence of the representatives of the insurance providers to give information on the available insurance products through sustained awareness campaigns.

Khan and Ahmed (2013) studied the impact of offering education on health insurance using weekly group discussions in Bangladesh. They observed that those informal sector persons who attended the sessions were more likely to enroll for health insurance compared to those that did not attend the sessions.

Mathauer *et al* (2008) studied the factors the factors affecting demand for health insurance services focusing into enrolment onto a national insurance scheme. They noted that the lack of knowledge about enrolment procedures and the basic principles of health insurance was a major barrier to the enrolment into health insurance services.

2.3 Attitude barriers to uptake of health insurance services

Enrolment decisions are also very important in the uptake of insurance schemes like; knowing peers that claimed, an informal trust-building factor, is the most important in explaining uptake of micro insurance (Morsink and Guerts, 2011), households having higher ratio of sick members are more likely to purchase insurance, explaining the existence of adverse selection and ex post moral hazard (Ito and Kono, 2010), insurance literacy of household members, but marketing treatment has a positive association with the take up decisions of households (Bonan *et al.*, 2012).

Morduch (2009) explain that households with more friends (especially richer ones) have greater ability to use health insurance; public transfers pool risks more efficiently than local private arrangements; reciprocal transfer systems work best when people have more money the family is the most stable unit for informal insurance.

In health insurance fear risk by family members is an another factor for failed uptake of health insurance with respect to the importance of community structure for informal risk-sharing, parallels can be drawn from a number of studies in the development economics literature. Rosenzweig and Binswanger, (1993) stresses the importance of kinship ties in sustaining information flows in acceptance to uptake health insurance, which are crucial to maintaining insurance-based private transfer arrangements across space and time. Grimard (1997) provides similar evidence from Cote d'Ivoire, and recent work by Foster and Rosenzweig (2001) concludes that altruism within families facilitates risk-sharing by overcoming problems of imperfect commitment and unenforceable contracts.

Risk aversion, price sensitivity of medical care and health status of the individual also constitute the personal characteristics underlying the decision to opt for health insurance. As indicated by Cutler and Zeckhauser (2004), the value of risk spreading increases with risk aversion and variability of medical expenditure. The necessary condition for informal risk sharing schemes to grow is the existence of voluntary exchange. This reciprocity however is sustained if discount rates of people are lower, that is if their degree of relative risk aversion is higher, and the differences between their respective incomes are larger.

Besley (2005) draws parallels between risk-sharing and credit, particularly in traditional rural communities, given that the latter tends to substitute for insurance when market opportunities are limited. For example, an individual may borrow in lieu of an insurance payment, and lenders frequently relent on part of a repayment in the event of an unforeseeable shock to the borrower. Townsend (2005) points out that insurance functions exist both implicitly and explicitly, a useful conceptual separation given the wide range of actions that fit into the framework of consumption smoothing, or risk-reduction.

Informal trust-building factors are equally or more important in explaining demand for insurance. Trust in insurance can relate to trust in the insurer or trust in the specific insurance product. If there is solidarity in the community or trust in management, it will positively influence individuals' decision to enroll in health insurance schemes (Dercon and Krishnan, 2002).

Informal risk-sharing is only partial and, hence, inefficient Cox and Jimenez (2002), a factor likely to influence expected utility under formal insurance. Dercon and Krishnan (2002) make a similar point in a review of the evidence, concluding that informal risk-sharing arrangements provide only limited protection for households, especially for the poor.

In regard to personal factors, females are often more likely to be enrolled Cutler and Reber, (1998);Jütting, (2004). Wang *et al.*(2006) and Kirigia *et al.* (2006) find that a higher age significantly increases the odds of owning a health insurance in respectively China and South Africa. The latter study theoretically explains this by individuals increasing investments in health in an attempt to decrease the rate of depreciation of health due to aging. Also Chernew and Reber (2008) show that older employees are more likely insured with a more generous healthcare plan.
According to Shaw and Ainsworth (2007), the choice of a health insurance plan and the extent of involvement by households are driven by two sets of determinants, which are closely related, but are analytically separable the characteristics of the plan itself, and the personal, household and community characteristics of the individual making the choice. The characteristics of the insurance plans involve the type of medical services offered, the degree of freedom to choose providers and the extent of compensation given (Zweifel and Breyer, 2008). The quality of care given by the chosen provider and perceived credibility of the insurer also affects uptake of the service (Asenso-Okyere, 2007).Failure to buy insurance among low risk or high-risk individuals,

as it is socially desired, is also influenced by asymmetric information between insured and insurers and plan regulation.

Some people feel dissatisfied with technical processes of the scheme. These included collection of cards, the opening hours of the scheme offices and the location of the scheme. These issues regarding the technical processes also render the scheme unattractive to some people as stated earlier in this discussion. Schneider (2005) argues that many insurance schemes operate within weakly defined legal and political systems; and are based on mutual, non-written agreements that are monitored and enforced by members. Sometimes managers often lack the technical capacities to manage an insurance scheme and negotiate with providers for better care.

The quality of services offered by providers under the scheme goes a long way to boost clients' confidence in the scheme and make the scheme more attractive to prospective clients. Besides, financial incentives created by the insurance providers' inferior quality of care may negatively affect MHIS membership. Providing quality health care increases the trust of clients in the health system and insurance in general. In this study, majority of respondents held negative perceptions about the technical quality of care, the adequacy of service delivery including rooms, medical equipment and doctors and the attitude of providers and these negatively influenced their decision to renew NHIS policy. This indicates that after one subscribes to the NHIS, his or her decision to renew the insurance is partly based on the quality of care from health providers. Consistent with this study, lack of quality of care was cited as the most important cause of non-enrolment in the evaluation of the Maliando scheme in Guinea.

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affect insurance scheme membership. Providing quality health care increases the trust of clients in the health system and insurance in general. Some people hold negative perceptions about the technical quality of care, the adequacy of service delivery including rooms, medical equipment and doctors and the attitude of providers and these negatively influence their decision to renew insurance policies. Consistent with this, lack of quality of care was also cited as the most important cause of non-enrolment in the evaluation of the Maliando scheme in Guinea-Conakry in the year 2003.

Mladovsky and Mossialos (2008) propose that trust decreases the likelihood of adverse selection and moral hazard and increases willingness to pay for healthcare. These include improving behavior of medical staff to patients, such as increased levels of politeness, improving quality of care, transparency and accountability among those managing the scheme; recourse to justice to punish fraud and increased community participation in the scheme management.

2.4 Financial barriers to uptake of health insurance services

Households with a higher income are more able to pay for insurance. This does not necessarily mean that they more likely enroll in health insurance as healthcare shocks or losses are relatively less severe. Enrollment is clearly wealth related; the propensity to be enrolled is seven times higher for persons from the highest quantile (Zhang and Wang, 2008).

Morduch (2009) suggests that by contributing to health schemes, households may actually retard their income growth and social mobility. He claims that overall, despite the crowding-out of informal networks, communities tend to benefit from government schemes.

Financial constraint is one of the major barriers of access to healthcare for marginalized sections of society in many countries (Garg and Karan 2009; Xu *et al.* 2003). It has been estimated that a high proportion of the world's 1.3 billion poor have no access to health services simply because

they cannot afford to pay at the time they need them (Dror *et al.* 2002). And many of those who do use services suffer financial hardship, or are even impoverished, because they have to pay (WHO, 2010).

Financial costs are only one of the potential barriers to access to health care; the severity of non-price barriers can also play a major role in health insurance acquisition, which results in variation of the impact of health insurance on healthcare utilization for some population groups (Wagstaff 2009; Basinga *et. al* 2010; Toonen *et. al* 2009). Health insurance coverage may be of limited value to households living in remote areas where the roads linking them to health facilities are poor and transport options are limited; these physical disadvantages may be compounded by low levels of education and skepticism over the benefits of Western medicine (Wagstaff 2009). Even with insurance, barriers in accessing healthcare include: distance to the nearest healthcare facility; lack of knowledge, skills and capabilities in filling forms and filing claims, lack of money to pay initial registration fees; and indifferent attitudes of doctors related to actual and perceived quality of care (Sinha *et al.* 2006).

The uptake of health insurance schemes is largely affected by credit flows within networks of families and friends and are essentially what Cox, Fetzer *et al.* (2008) analyze using data from the Vietnam Living Standards Survey 1992-3, concluding that as private transfers tend to flow into poorer households, in a similar way to means-tested public transfers, there is a possibility that the two are substitutes, and that the former is crowded out by the latter. They add that, as private transfers are widespread in Vietnam, the scope for such crowding-out is substantial. In an earlier paper, Cox and Jimenez (2001) categorize private transfers into those that are motivated by altruism, and those motivated by exchange.

To achieve universal health care coverage, an institutional structure that emphasizes payment to providers for services delivered has been offered to those beyond the formal workforce. Although schemes for the poor may share the same administrative structure others usually offer a reduced package or restrictions on providers. Free-standing schemes offer financial protection to the poor through subsidized, usually voluntary household enrollment into a defined benefits arrangement (Wagstaff, 2009). Insurance is offered at premiums that are considerably below the actuarially fair price. Given that most employment in low and middle-income countries is informal, governments manage compulsory insurance in the formal sector with limited avenues to cross-subsidize the informal sector. Thus, health insurance is tax financed, although funding for it may be ring-fenced.

Starting from a point of low utilization by the formal sector, both free care and prepayment of financing for care are implemented to encourage use for illness or to increase contact with health workers to facilitate better delivery of preventive care. From the perspective of the user, prepayment insurance schemes, whether highly subsidized or zero-entry fee, should be understood differently than free care. Even if the entry fee is small, some households may not be able to afford the fee. Sparrow *et al*, (2008) report that in Indonesia, it may be costly to provide photos of household members for insurance cards. At the point of care, there may be copayments to limit frivolous care-seeking behavior because of the extremely low marginal cost of seeking care if zero copayments prevail (Shi, 2010).

Although the existence of user fees give people a strong incentive to enroll in insurance schemes, the institutionalization of user fees within health care providers' practices presents an obstacle to the effective implementation of insurance schemes. Introduction of a scheme alters the power relationship between the provider and the individual consumer and requires changes in

organizational culture and behavior. The provider may have to negotiate and contract with patients who interact with health care institutions as a collective group and as direct sponsors (Eklundand Stavem, 2000).

The cost of health insurance premiums deters some members from taking up health insurance schemes. Several authors discuss the determinants of enrollment such as high cost of premiums, distance to health facilities, place of residence, poor quality of care, timing of premium payments and other behavioral and social factors (Sinha *et al,* 2005). Wang *et al,* (2006) explained that there is difference between the rich and the poor with respect to price elasticity of health insurance.

Wang *et al,* (2006) further explain that the price of insurance or premium is another factor influencing the demand for health insurance. The decision to enroll in is significantly influenced by perception about the premium package for the insurance and the registration fee. Affordability of premiums or contributions is often mentioned as one of the main determinants of membership in other studies. For instance in the Nkoranza Scheme in Ghana, the estimated cost of contributions varied from 5% to 10% of annual household budgets and it was recognized that such contributions could be a financial obstacle to membership.

The supply-side barriers relate to schemes' design and management for example, lack of clarity among scheme staff regarding the scheme's rules and processes, and requirements that claimants submit documents to prove the validity of their claims to accessing benefits in a community-based insurance scheme which affect take-up decision in the scheme (Sinha *et al.*, 2005).

Among the solutions proposed within various low- and middle-income countries to reduce costs to households at the point of care is the establishment or extension of national or social health insurance (SHI) in which service providers are paid from a designated government fund, which

is partially funded through taxes. These SHIs are primarily intended for those employed outside of the formal sector. The WHO (2010) and the World Bank (2010) have endorsed the restriction of out-of-pocket expenditures for health care at the time of use through the prepayment of insurance as an important step toward averting the financial hardship associated with paying for health care(Hsiao and Shaw, 2007). The impact of insurance, even when properly implemented, is not clear from the outset in low- and middle-income countries. Awareness of and trust in public programs, distance to health care facilities and institutional rigidities within the health care system can play major roles in limiting insurance enrollment and its related effects (Wagstaff 2007; Basinga *et al.* 2010).

An effective health care system that includes insurance and other forms of social protection should provide much broader financial risk protection. Miller *et al.* (2009) mention, in passing, the important issue of whether health insurance can go beyond reducing health care costs to eliminate significant adverse effects of health shocks so that households can maintain their standard consumption and saving bundles (Chetty and Looney 2006). Some studies used the measure of catastrophic payment, defined as a threshold proportion of all expenditures, which is spent on health. The denominator varied across studies, as did the threshold levels.

Few countries in the developing states provide protection against cost for health care for all or most of the population. This has resulted in great financial burden for those using the health services, mostly those working in the informal sector. Those in the formal employment are more secure financially and also more easily drafted into health insurance scheme. This is because their income is known and can be taxed at source. Therefore, steps taken by government and international agencies and NGOs to protect those in the informal sector against health care cost at the point of use are increasing the uptake of community financing. A well designed and

managed system for those outside formal employment may be a potential means of improving health care services (World Bank, 2009).

Allowing communities to give to health care and the extent of their contribution between sick and healthy people, resources for health care delivery can be mobilized. This can be used to increase financial risk protection, improve quality of health care and increase accessibility. Because of the widespread interest in expanding health insurance coverage, there has been a parallel interest in evaluating the impact of health insurance programs in terms of their effects on utilization, out-of-pocket spending and health outcomes (Wagstaff, 2009).

Risk adjustment would function in the background to move funds from plans that enrolled predictably low-cost enrollees to those that enrolled predictably high-cost people. It would also reduce incentives to avoid chronically ill and disabled enrollees and seek out healthy ones. However, risk adjustment is easy to say and much harder to do. For example, it requires distinguishing between high costs attributable to having sicker enrollees and high costs attributable to inefficient care provision. Risk adjustment should not punish plans that achieve low costs through efficient management rather than selection. No risk adjustment scheme will ever be sensitive enough to match the variation in health costs across individuals, meaning that there will always be a financial incentive to figure out what distinguishes the high-cost people in any group from the low-cost people. But risk adjustment need not be perfect; it need only make risk selection a less effective way to control costs than care management and other efficiencies.

It is important to focus on benefit comparability just as it is necessary to limit variation in premiums that individuals can be charged to make guaranteed issue viable, so too it is necessary to specify what the insurance benefit covers. Without standards governing cost sharing, covered services, and network coverage, there is no way to assess whether requirements to purchase or

issue coverage have been met. This is a highly charged issue that, along with the individual mandate, confronts the freedom of purchase issue head on. However, the practical reality is that the status quo with its relatively complete freedom to buy whatever insurance product the market can dream up is not achieving a desirable outcome. Economists generally argue in favor of consumer choice because having more choices increases social welfare when they are cheap to accommodate and decisions are not interdependent (Jutting, 2004).

Subsidize insurance for low-income Individuals and families. A mandate to purchase health insurance would only be feasible and only be fair, if it did not impose undue financial hardship. For low and middle-income workers, premiums for even a modest package of benefits could easily consume an unreasonable share of income. Subsidies introduce a host of difficult technical and policy questions about how to pay them, at what level of income to phase them out, and whether they reinforce or counteract competitive forces (Jakab and Krishnan, 2004).

2.5 Conclusion.

The literature review related to health insurance uptake in developing countries reveals that knowledge, attitude and financial barriers continue to limit the uptake of health insurance services. Furthermore, limited research to the uptake of health insurance specific to Uganda has been carried out, especially in the informal sector. Therefore the justification for this study to be carried out.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

The objective of the study was to examine the relationship of knowledge, financial and attitude barriers to the uptake of health insurance services in the informal sector in Central Division, Kampala City.

The chapter presents the methodology that was followed to answer the study questions. The chapter presents the research design, study population, sample size, sampling methods, data collection methods and instruments, pretesting of instruments, procedure for data collection, validity and reliability, data management and analysis, measurement of variables, ethical considerations and limitations of the study.

3.1The Research Design

The research design is a conceptual structure in which research is conducted and finally concluded. It lays down rules for the selection of the data, collection of data and treatment of the findings. The choice of research design depends on the nature of the problem on which the study is being undertaken and the scope of the study.

This study adopted a case study research design to answer the research questions using both qualitative and quantitative approaches. The questionnaire was designed to collect both quantitative and qualitative data. The items in the sur0vey questionnaire both were closed-ended, did not require respondents to be probed for their answers, while other items were open-ended and required respondents to be probed for the answers.

This approach was chosen because according to Creswell (2003), concurrent data collection saves time and integration in data analysis can result in well validated and substantial findings.

During the analysis, both quantitative data and qualitative data were used to complement each other to understand the research problem.

3.2 Study Population

In the context of research, Population is defined as "all the members or objects of any defined group which might be taken or about which information might be given". It is also a group where the researcher would like to sample from and is interested to generalize to (Trochim, 2007). It is therefore essential to identify the population precisely and accurately because inferences have to be made about the elements in the population.

The study population involved the informal businesses operating in Central Division, Kampala City. At the time of the commencement of the study, 198 informal businesses had valid trading licenses on the selected streets and were considered as the study population.

3.3 Sample Size

According to Mugenda and Mugenda (2003), it is impossible to study the whole targeted population and therefore the researcher has to decide on a sampled population with guidance from the formula below.

$$\mathbf{n = \frac{N}{1 + N(e)^2}}$$

Where n = sample size, N= population size e = level of precision = 0.05

The sample size of the study is presented in the table below.

Table 1: Number of study participants

Category	Population	Sample size	Sampling Strategy
Informal businesses in Kikubo lane	60	52	Purposive and simple random
Informal businesses in Market Street	45	40	Purposive and simple random
Informal businesses in Ben Kiwanuka Street	50	44	Purposive and simple random
Informal businesses in Luwum street	43	39	Purposive and simple random
Total respondents	**198**	**175**	

3.4 Sampling Techniques

The study used both purposive sampling and simple random sampling respondents on the four streets to include in the study. The purposive sampling technique, also called judgment sampling, is the deliberate choice of an informant due to the qualities the informant possesses. The researcher decides what needs to be known and sets out to find people who can and are willing to provide the information by virtue of knowledge or experience (Bernard, 2002)

Purposive sampling was used because it helped the researcher to focus on particular characteristics of the target population that are of interest (the informal sector business persons), which answered the set out research questions. The researcher then used simple random sampling on those that met the criteria to come up with the final sample.

3.5 Data Collection instruments

The study utilized both qualitative and quantitative data collection methods. Primary data was obtained using questionnaires.

3.5.1 Questionnaires

A survey questionnaire is the tool that was used to collect data in this study as it is considered as a reliable tool for collecting information directly given by the respondent. A questionnaire has been defined as "paper-and pencil instrument that the respondent completes" (Trochim, 2007: 108). Such information may consist of attitudes and beliefs, experience and status of respondents or events. This information can be both qualitative- verbal description, comments or views and quantitative- numbers, enumerations on scores as in the case of rating scale or opinion scores elicited on attitude scale. This study, therefore, employed a questionnaire as a tool to collect both quantitative and qualitative data on the views of the informal sector business persons on the uptake of health insurance services. The questionnaire was developed through the review of related literature from different sources including journal articles, theses, dissertations, and health insurance policy documents.

The questionnaire was logically divided into different sections and self- administered. The use of self-administered questionnaire was anticipated to provide informal sector business persons with flexibility in completing the questions as Brymann (2004) puts it, "the participants can complete the questionnaire when they want and the speed they wanted to go". In other words the questionnaire allowed the informal sector business persons to respond to questions by filling out at their own convenience within the given time schedule.

The selection of data collection tools also greatly depends on: the nature of the problem under study, availability of resources, time factor and desired degree of accuracy (Kothari and Garg, 2014). According to Bell (2007), a questionnaire is a suitable method for a single researcher, who does not have a lot of funds, and has to complete the research project in a limited amount of time. The above points identified by Bell did also apply to this study, as the researcher did not have sufficient funds to apply different research instruments and had a limited time for data collection, analysis of the data and report writing.

The study had one set of questionnaire that was constructed to capture all the necessary information from all categories of respondents in respect to the themes of the study. The questionnaire was administered door to door since most of the respondents in this category were available at their places of work.

The questionnaire was divided into four sections. Each section consisted of closed-ended items and open-ended items. The first section of the questionnaire consisted of items that were aimed at capturing the biographic information of the informal business persons. The second section consisted of 10 items that are related to knowledge barriers. The third part consisted of 11 closed-ended items related to attitude barriers. The fourth section consisted of 9 closed-ended items related to financial barriers. The scale of measurement for the closed-ended items in the four sections of the questionnaire was a five Likert scale i.e. Strongly Agree, Agree, Not Sure, Disagree and Strongly Disagree. In the questionnaires, informal business persons were required to respond to all closed- ended items by indicating the right opinion by ticking in the proper place provided against each statement. The respondents were required to write down their responses for the open-ended items.

3.6 Data quality control Procedures

3.6.1 Validity

Validity is an important characteristic of research. Weirsma (2000) categorizes validity of research as internal validity, which is considered as the extent to which results of research can be interpreted accurately and with confidence while external validity is considered as the extent to which the results of the study are generalizable to population and conditions. De Vaus (2002) considers a valid instrument to that one measuring what it is intended to measure. The validity of the tool depends upon the efficiency with which it measures what it attempts to measure. In other words, it is the accuracy with which the tool measures what it claims to measure. The term validity and purpose of the tool are closely associated with each other.

Validity of an instrument can be classified under four categories: content, predictive, concurrent and construct validity. For this two categories of validity will be taken care of, and these are content validity and construct validity. Content validity which is based on judgment is sometimes referred to as logical or curricular. In this study, the content validity of the data collection tools will correspond to the content of research they were designed to measure. This involved specifying the domain of content for each research question. In this study, content validity involved item validity. Item validity was concerned with whether the items in the questionnaires represented measurement in the intended content area. Therefore, to ensure content validity of the questionnaire items, the questionnaires were sent to field experts who included senior medical personal who are well versed with the area of health insurance uptake services. These experts examined the items of the questionnaires systematically and indicated whether they measured what they were intending to and their views were taken into consideration.

The study adopted content validity which is the degree to which data collected using particular instruments represents a specific domain of indicators or content of a particular concept. To ensure content validity of instruments, the researcher constructed the instruments with all the items that measure variables of the study. The researcher also consulted the supervisor for proper guidance after which the researcher pre-tested the instruments and removed ambiguous questions or polished them so as to capture the finest data required.

3.6.2 Reliability

Reliability is the degree of accuracy of the instrument to produce almost identical results if its used in a different study. Data collection tools were pretested on a smaller number of respondents from each category of the population to ensure that the questions are accurate, clear and in line with objectives of the study. The initial pilot testing was conducted with a total of 20 informal business persons.

Four methods can be used to measure relaibility of an instrument and these include: retest method; alternative form method; split-halves method; and internal consistence method. In this study, the relaibility of the questionnaires was determined by internal consistence method by calculating the Cronbach Alpha for all the categories in the questionnaires. The acceptable Cronbach Alpha should be at least 0.70 (DeVellis, 2003). The Cronbach Alpha value for the items in the questionnaire for this study was 0.841, which above the recomended acceptable value.

3.7 Data Collection procedures

The researcher obtained a letter of introduction from Uganda Martyrs University (UMU) to help with introductions to the respondents.Before the questionnaires were distributed to the informal

business persons, a brief discussion was first held with the selected respondents. During the brief discussion the respondents were introduced about the research study focusing on its purpose. Also the respondents were again reminded of the voluntary nature of participation in the study, the right to withdraw any time as well as the maintenance of confidentiality. If the informal business persons agreed to participate in the study a questionnaire was distributed to be filled in at his/her own convenience. The researcher kept in touch with the respondents who would submit the questionnaires upon completion.

3.8 Data Analysis

The study generated both qualitative and quantitative data. In analyzing the quantitative data from the survey questionnaire, the ratings from the Likert scale were numerically coded as: 5- Strongly Agree, 4- Agree, 3- Neutral, 2- Disgree and 1- Strongly Disagree. Respondents' answers were entered into the Statistical Package for the Social Sciences (SPSS), version 20.1 for analysis. Descriptive statistics were generated on each of the items in the questionnaire. These descriptive statistics included frequencies, percentages and mean for every item.

Data analysis of qualitative data in the objectives of the study used content analysis where each piece of work answered for open-ended items was read through thoroughly to identify themes and where they belong. The study also used quotations and narrative statements to represent respondents' views.

3.9 Ethical considerations

Ethical considerations rest on fairness, honesty, openness of intent, disclosure of methods, confidentiality guarantees, and voluntary and informed consent (Levine, 2005). Thus, the researcher endeavored to uphold the confidentiality of the sources of data by assuring

respondents that the study is purely for academic purposes. The researcher also upheld the principle of informed consent such that participants appreciate the need to take part in the study. An explanatory statement that clearly documents the purpose of the study and the voluntary participation was prepared. Participants were assured of the anonymity and confidentiality with the self-administered questionnaire data. The informal business persons were also informed that they were free to withdraw from the study at any time before submitting in the questionnaire. The participants were informed that in case of any complaint concerning the manner in which the study is being conducted, they were free to contact my supervisor who would then pass on the complaints to the Dean, Faculty of Business Administration and Management at Uganda Martyrs University.

3.10 Limitations of the Study

Collecting data from business people who seemed to be busy and operating informally was a significant challenge. This considerably slowed down the process of data collection. However persistence, persuasion and patience were exercised to successfully manage the challenge.

Determining the population and sample size for the study was a challenge, considering the unregulated nature of the businesses. The study considered those businesses that had a valid trading license at the time and this certainly left out a considerable part of the population.

3.11 Conclusion

The chapter covered the methodology that was followed to ensure that the study adequately answered the study questions. The chapter presents the research design, study population, sample size, sampling methods, data collection methods and instruments, pretesting of instruments,

procedure for data collection, validity and reliability, data management and analysis, measurement of variables, ethical considerations and limitations of the study.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.1. Introduction

The study examined the relationship between barriers and the uptake of health insurance services in the informal sector in the Central Division of Kampala city. The study adopted three research objectives which looked at knowledge barriers, attitude barriers and financial barriers to the uptake of health insurance services in the informal sector.

The study presents descriptive results from closed-ended items in form of frequencies, percentages and mean. Also the study presents qualitative results from open-ended items in form of quotations and narrative themes as per respondents' views in regard to each objective of the study. The chapter also presents the response rate, which shows the actual number of respondents that participated in the study from the anticipated number of respondents. The study also presents the background information of respondents which shows the age, sex and education status of respondents that participated in the study.

4.2 Response rate

In this study, 175 questionnaires were given out to potential respondents. Of these, 137 questionnaires were returned. This represents a response rate of 78.2% which is well above the 50% response rate considered adequate for analysis and reporting as recommended by Mugenda and Mugenda (1999). Therefore, the study results can be relied upon for academic and non-academic purposes.

4.3 Background Information

This study sought to establish background information of respondents in form of Gender, level of education and age. This was aimed at establishing the ability of the respondents to give relevant and useful information to the study as well as identify those characteristics that would influence decision making in the uptake of health insurance services. The results are presented in their respective tables and figures below.

4.3.1 Gender of the respondents

The table below shows the gender distribution of the respondents.

Table 2: Gender of respondents

Gender	Frequency	Percent (%)
Male	72	52.6
Female	65	47.4
Total	137	100.0

Table 2 shows that 52.6% of respondents that participated in the study were male where as 47.4% were female.

4.3.2 Level of Education

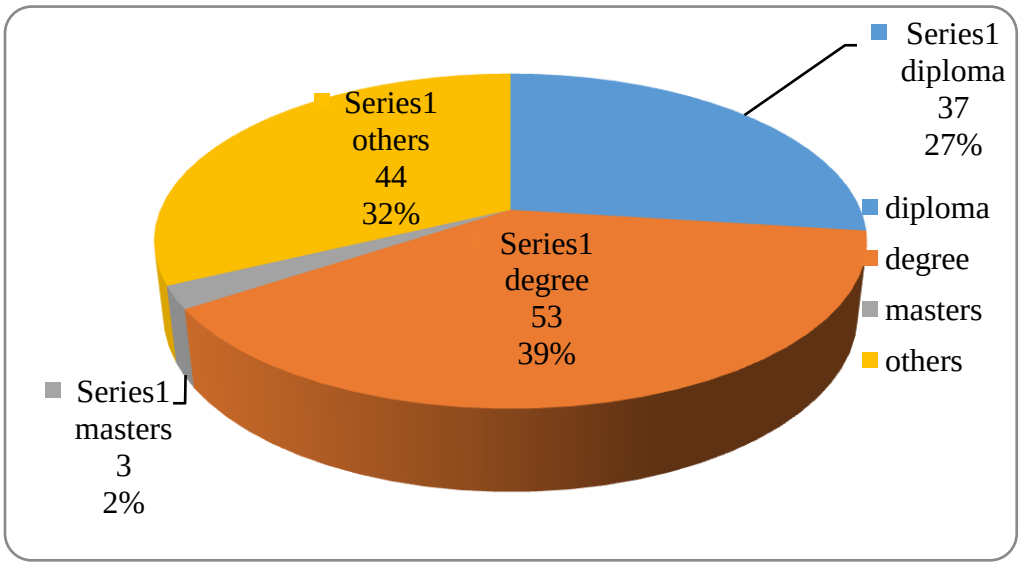

Figure 2: Level of education of the respondents

Figure 2 shows that 39% of the respondents had bachelor's degree as the highest education level, 27% had diplomas and while 32% were below diploma level. Only 2 % had master's degrees. Therefore majority respondents had a level of education that would help them read and understand or interpret the major concepts in insurance and such would enable its uptake.

4.3.3 Age of Respondents

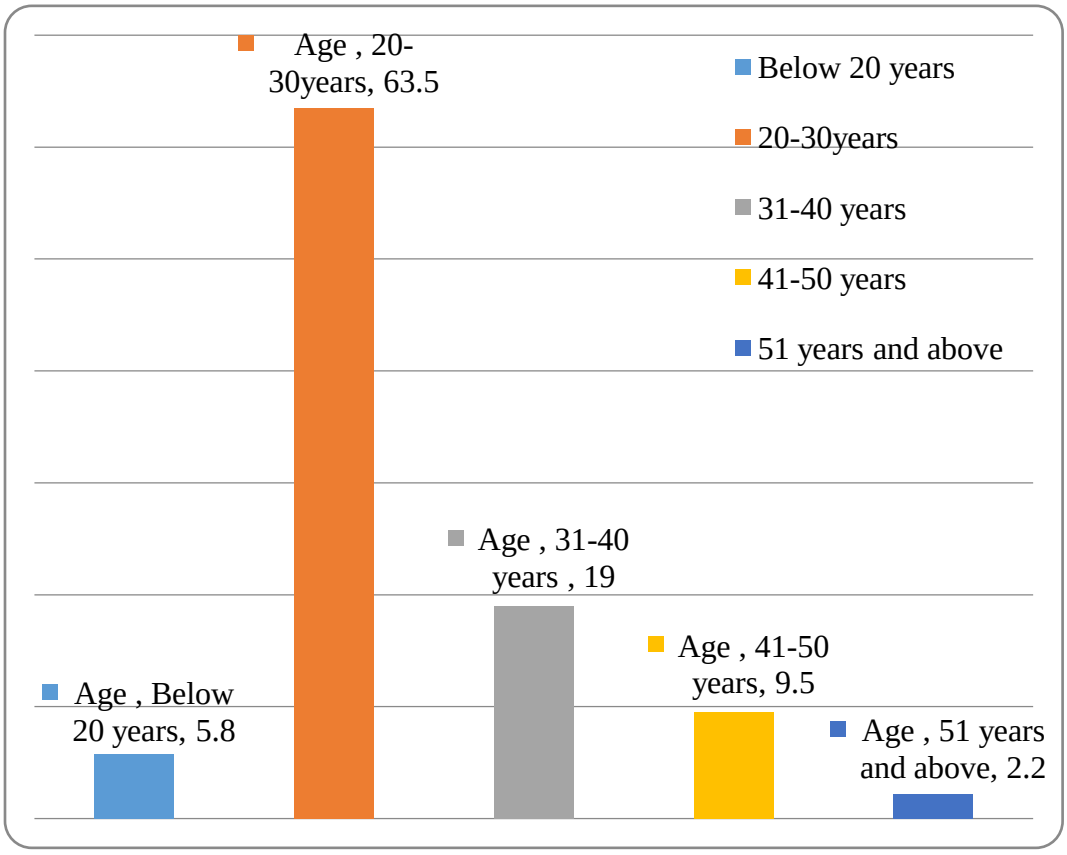

Figure 3: Age of respondents

Study findings in Figure 3 show that63.5% of respondents that participated in the study were aged between 20-30 years, 19% were aged between 30-40 years of age, where as 9.5% were aged between 40-50 years, 2% were aged above 51 years and 5.8% of respondents were aged below 20 years of age. From the findings, majority respondents were below the age of 40years and this implies that majority of participants were adults who are more likely to comprehend the questions asked and provide responses that are relevant to the study.

4.4 Knowledge barriers to health insurance services uptake in the informal sector

The study examined the knowledge barriers to health insurance services uptake in the informal sector in the central division of Kampala city. The various knowledge barriers were looked at in regard to premiums available, insurance coverage benefits or packages, exclusions, and cost sharing. Responses to close ended items from questionnaires were computed to obtain frequencies and percentages and mean as presented in Table 3 below. Responses to open ended items are presented in form of quotations.

Table 3: Items relating Knowledge barriers to uptake of health insurance services in the informal sector

Knowledge barriers to the uptake of health insurance.	**SD**		**D**		**NS**		**A**		**SA**		**Mean**
	F	%	F	%	F	%	F	%	F	%	
No one has come to me to sensitize about health insurance	11	8	10	7.3	5	3.6	45	32.8	66	42.2	4.06
I don't know about insurance premiums, payments and how they work	6	4.4	15	10.9	5	3.6	61	44.5	50	36.5	3.99
I don't have knowledge on the different indirect and direct insurance benefits packages	13	9.5	15	10.5	11	8	54	39.4	44	32.1	3.74
I don't know about the medical services that are covered under health insurance	17	12.4	17	12.4	7	5.1	52	38	44	32	3.65
I don't know where to get information on health insurance services	14	10.2	46	33.6	3	2.2	37	27	37	27	3.27

I don't know the key challenges associated with health insurance policies	10	7.3	18	13.1	5	3.6	64	46.7	40	29.2	3.77
I do not know about the exclusions associated with health insurance	8	5.8	11	8	16	11.7	60	43.8	42	30.7	3.85
I don't have knowledge on health insurance risk pooling	15	10.5	11	8	12	8.8	66	48.2	33	24.1	3.66
I don't have knowledge on where to get an effective and efficient health insurance service provider	17	12.4	19	13.9	20	14.6	53	38.7	28	20.4	3.41
I don't have knowledge on affordable insurance products	9	6.6	19	13.9	12	8.8	51	37.2	46	33.6	3.77

Table 3 shows the analysis of responses item by item that are related to knowledge barriers to the uptake of health insurance services in the informal sector. The mean scores revealed that most of the respondents strongly agreed or agreed with the items of discussion. 75% of the informal business persons either agreed or strongly agreed that they had not been sensitized about insurance. This was also the item with the highest mean score of 4.06. 71.5 % of the respondents either agreed or strongly agreed that they don't have knowledge on indirect and direct insurance benefits packages. The corresponding mean score for this item was 3.99. 81% of the respondents either agreed or strongly agreed that they do not know about insurance premiums, payments, and how they work. 70% either agreed or strongly agreed that they do not know medical services that are covered under health insurance services. 54% of the respondents either agreed or strongly agreed that they don't know where to get information on health insurance services. 75.9% of the

respondents either agreed or strongly agreed that they don't know the key challenges associated with health insurance policies. 74.5% of the respondents either agreed or strongly agreed that they don't know about the exclusions associated with health insurance. 72.3% of the respondents either agreed or strongly agreed that they don't have knowledge on health insurance risk pooling. 59.1% of respondents either agreed or strongly agreed that they don't have knowledge on where to get an effective and efficient health insurance service provider. 70.8% of the respondents either agreed or strongly agreed that they don't have knowledge on affordable insurance products.

Some of the responses to the open ended items related to the knowledge barriers to the uptake of health insurance services in the questionnaire are presented below. These represent the views of many informal business persons that participated in this study.

> *"….No one has ever explained to me so that I can join, I don't have the information about health insurance services therefore I cannot become a member,…it's a barrier because some of us know nothing about health insurance….I have never enrolled and I don't think I will ever join…."*

> *"…..Should I understand that the services are good, I would enroll … This thing would have been good if I had any information concerning this health insurance services… I would wish to uptake health insurance if I knew or had information about the services…."*

> *'Some people in the informal sector would join health insurance if the insurance services and benefits were explained to them well. But they currently lack the information to join.'*

"....I do not have the knowledge about the health insurance services and this does affect me because I spend a lot of money in covering the medical bills and yet the insurance would have helped me..:."

4.4.1 Correlation between knowledge barriers and health insurance services uptake in the informal sector

Results from a correlation analysis between knowledge barriers and health insurance services uptake in the informal sector was obtained and results are presented in the table below.

Table 4: Correlation between knowledge barriers and health insurance services uptake in the informal sector

Correlations			
		Uptake	Knowledge Barriers
Uptake	Spearman's Rho Correlation	1	.773**
	Sig. (2-tailed)		.000
	N	137	137
Knowledge Barriers	Spearman's Rho Correlation	.773**	1
	Sig. (2-tailed)	.000	
	N	137	137
** Correlation is significant at the 0.01 level (2-tailed).			

Table 4 shows that the uptake of health insurance services and the knowledge barriers have a strong, positive significant correlation, $r(135) = 0.773$, $p \leq 0.00$. This indicates that in a situation where people in the informal sector have enough knowledge on premiums available, insurance coverage benefits or packages, exclusions and cost sharing then there is a likelihood that insurance uptake will improve among the informal sector people.

Responses from both open-ended items and close-ended items revealed that most people in the informal sector lack adequate information on health insurance services. Most people in the informal sector do not have enough information on the premiums offered by the health insurance institutions; the associated exclusions and the products offered in the market. The findings of this study are similar to the findings of the study carried out by Sinha *et al.* (2006) who also found that lack of knowledge inhibits uptake of health insurance services.

This lack of knowledge among the informal sector business persons is explained by the fact that the stakeholders in the insurance sector have not targeted or prioritized the informal sector to sensitize them on the various products offered by the insurance industry and their benefits.

Information provision and process is important if informal sector is to effectively uptake health insurance services. Rosenzweig (1988) further stresses the importance of sustaining information flows in acceptance to uptake health insurance, which are crucial to maintaining insurance provider-client relationship.

This relates to Lionberger's(1960) diffusion theory which asserted that people process and accept information by going through five stages which is not done impulsively. The stages include; awareness stage where the individual is exposed to the idea but lacks knowledge of its benefit the interest stage is when the idea arouses the individual who assess the possibility of using it, evaluation stage where the individual must consider whether the idea is potentially useful and of

benefit to them, trial stage is when the individual tries out the idea on himself and others in order to conclude how he can benefit adoption stage which represents final acceptance of the idea and using it consistently based on continuous satisfaction.

This therefore implies that if people have no knowledge about a service, they will not have interest in using it or paying for it and this has largely reduced the levels of health insurance uptake in the informal sector. If the different players in the industry endeavored to reach the informal sector business persons and provide them with increased and improved knowledge, it is assumed that the uptake would also be improved. This explains the fact that the uptake levels of health insurance services are defined by the level of knowledge about insurance services in the sector.

Also most do not know about health insurance services, their benefits and costs since there is lack of communication about health insurance in the informal sector and this reduces their chances and level of uptake of health insurance services. Weinstein, (2009) explains that in insurance, individuals tend to have an optimistic bias towards their personal risks as the result of lack of information on insurance schemes. Underestimation of one's health risks leads to insufficient insurance levels, while those who are prone to chronic illnesses may enroll as actual costs are usually higher than the enrolment costs. This implies that if people have less information on insurance benefits then there will be low uptake of health insurance in the informal sector.

Providing information to cover the knowledge gaps will help the potential clients to find the particular health insurance packages which may be affordable and suitable for them to purchase. Responses to both open ended and close ended items in the questionnaire further revealed that the idea of health insurance services has not been put out clearly for the people to understand

especially in the informal sector. Most people do know about the benefits or the challenges that are associated with health insurance. Others in the informal sector have the need for the service but do not have enough information on the products.

This implies lack of knowledge and information on where to get the insurance packages and lack of information on such packages significantly contributes to low uptake of health insurance in the informal sector. Vogel, (2010) explains that constraints that have hindered attempts to design appropriate community insurance schemes include lack of information, the policy environment, inadequate administrative infrastructures, and a shortage of trained staff to manage schemes. This underscores the need for information on the feasibility of schemes that are designed for the informal sector. Affordability of premiums and appropriateness of payment schedules are key challenges.

4.5 Attitude barriers to health insurance services uptake in the informal sector

The study sought to examine attitude barriers to health insurance services uptake in the informal sector. The various attitude barriers studied included affordability, risk perception, trust in management and alternative payments.

Table 5 below shows the responses of informal business persons that were computed to obtain frequencies and percentages. Findings from open-ended items were presented as quotations.

Table 5: Items relating attitude barriers to the uptake of health insurance services in the informal sector

Attitude barriers to health insurance services uptake	SD		D		NS		A		SA		Mean
	F	%	F	%	F	%	F	%	F	%	
Health insurance is expensive and designed for those in formal employment only	18	13.1	28	20.4	19	13.9	24	17.5	48	35	3.41
I don't trust the promises given by health insurance service providers	20	14.6	30	21.9	26	19	40	29.2	21	15.3	3.09
Access to Health insurance services is a complex processes	11	8	20	14.6	32	23.4	45	32.8	29	21.2	3.45
There are no flexible premium payment options	8	5.9	15	11	19	14	39	28.7	55	40.4	3.89
Takes a lot of time and procedure to enroll	9	6.6	22	16.1	26	19	45	32.8	35	25.5	3.56
Products are not designed for the low income persons	17	12.4	24	17.5	23	16.8	40	29.2	33	24.1	3.35
Negative experience with agents who mislead clients	19	14	30	22.1	25	22.1	39	28.7	23	16.9	3.10
Insurance health companies don't give quality services	54	39.7	34	25	24	17.6	10	7.4	14	10.3	2.22

Table 5 shows the analysis of the items related to attitude barriers to the uptake of health insurance services in the informal sector. 53.5% of respondents either agreed or strongly agreed

that health insurance is expensive and a preserve to those persons who are in formal employment only. 44.5% of the respondents either agreed or strongly agreed that they don't trust promises by health insurance service providers. 54% of the respondents either agreed or strongly agreed that access to health insurance services is a complex process. 69.1% of the respondents either agreed or strongly agreed that there are no flexible premium payment options; 58.3% of the respondents either agreed or strongly agreed that it takes a lot of time and procedure for one to enroll for health insurance services. 53.3% of the respondents either agreed or strongly agreed that the products of health insurance services are not designed for low income persons.45.6% of the respondents either agreed or strongly agreed that negative experience with agents who mislead the clients. 17.7% of the respondents either agreed or strongly agreed that health insurance health companies do not give quality services.

Some of the responses to the open ended items related to the attitude barriers to the uptake of health insurance services in the questionnaire are presented below. These represent the views of many informal business persons that participated in this study.

"…… most people have the phobia that it is meant for the rich people only… it is expensive, designed for the rich people…."

"…we only seek treatment when we fall sick. Seeking medical insurance is wastage of money….people may take long to fall sick or not fall sick, hence a waste of money.

"….they think it's one way of stealing from people….Again if I do not fall sick, then my money will have been taken for no reason…. the insurance companies want to make profits from us only…the insurance companies want to make profits from us only…"

"…many may take insurance to be a gamble and end up not taking the service…I can use that money in business instead of giving it out to the insurance company after all I don't live to remain sick all the time. I can use the profits for treatment…."

4.5.1 Correlation between attitude barriers to health insurance services uptake in the informal sector

Results from a correlation analysis between attitude barriers and health insurance services uptake in the informal sector are presented in the table below.

Table 6: Correlation between attitude barriers to health insurance services uptake in the informal sector

Correlations			
		Uptake	Attitude Barriers
Uptake	Spearman's Rho Correlation	1	.628**
	Sig. (2-tailed)		.000
	N	137	137
Attitude Barriers	Spearman's Rho Correlation	.628**	1
	Sig. (2-tailed)	.000	
	N	137	137
** Correlation is significant at the 0.01 level (2-tailed).			

Table 6 shows that the uptake of health insurance services and the attitude barriers have a strong, positive significant correlation, r (135) = 0.628, $p \leq 0.00$. This indicates that in a situation where people in the informal sector have a positive attitude to health insurance services, the uptake of the services should also improve. In the study, it was revealed that there is a positive significant relationship between attitude barriers to health insurance services uptake in the informal sector. The relationship between the two variables is explained by the correlation coefficient of .628 with a significance value of .000. Since the p-value is higher than 0.01 the relationship is significant. This implies that in a situation where people in the informal sector have a positive attitude towards affordability of insurance services, risk perception, trust in management, alternative payments then uptake health insurance services is more likely to significantly improve. Therefore where people in the informal sector have a positive attitude towards affordability of insurance services, risk perception, trust in management, alternative payments then uptake health insurance services is more likely to significantly improve.

This perception however affects the uptake of health insurance services especially among the informal sector members. This relates to Sinha et al, (2005) who explain that the cost of health insurance premiums deters some members from taking up health insurance schemes. Several authors discuss the determinants of enrollment such as high cost of premiums, distance to health facilities, place of residence, poor quality of care, timing of premium payments and other behavioral and social factors. Wang et al, (2005) explained that there is difference between the rich and the poor with respect to price elasticity of health insurance

In the study, it was revealed that there is a negative attitude that health insurance is only meant for the rich and those in formal employment and not those in the informal sector in fact one of the respondents explained that

This implies that the informal sector people have a belief that health insurance is expensive for low income earners and they cannot afford to access such services. People have an attitude that most people in the informal sector cannot afford the premium of insurance. Such attitude barrier for example people believing that health insurance is designed for a particular group affects and explains the lower uptake of health insurance services. The negative attitudes largely determine whether a person in the informal sector is likely or not likely to uptake the health insurance services. As Wang et al, (2005) explain that the price of insurance or premium is another factor influencing the demand for health insurance. The decision to enroll in is significantly influenced by perception about the premium package for the insurance and the registration fee. Affordability of premiums or contributions is often mentioned as one of the main determinants of membership in other studies.

In study it was revealed that people in the informal sector have negative attitude towards insurance, since some think it's a waste of money since some may take a lot of time for example in a year to fall sick so respondents think this would waste their resources in form of money, in fact one of the respondents explained that

Therefore such negative attitude leads to low uptake of insurance services and failure by prospective clients to take on health insurance services. It makes few people to take insurance covers from the service providers. The informal sector people who hold such negative beliefs may never uptake health insurance services if not well sensitized to change this form of attitude and this affects the levels of health insurance uptake in the informal sector.

Results indicate that there is a challenge of trust towards the health insurance service providers. People in the informal sector think that health insurance companies have ulterior motives to

defraud them and health insurance premiums are expensive. This affects the level of uptake of health insurance services among the informal sector. Informal trust-building factors are equally or more important in explaining demand for insurance as Dercon and Krishnan, (2002) argue that trust in insurance can relate to trust in the insurer or trust in the specific insurance product. The lack of trust in insurance organizations because they are viewed as profit making businesses will therefore affect the uptake of health insurance services.

To a large extent, the negative attitudes towards health insurance by the informal sector affect the uptake of the services. This relates to Morsink and Guerts, (2011) who explain that enrolment decisions are important in the uptake of insurance schemes like; knowing peers that claimed, an informal trust-building factor, is the most important in explaining uptake of micro insurance households having higher ratio of sick members are more likely to purchase insurance, explaining the existence of adverse selection and ex post moral hazard (Ito and Kono, 2010), insurance literacy of household members, but marketing treatment has a positive association with the take up decisions of households (Bonan et al., 2012)

Respondents have a perception that health insurance services do not have flexible premium payments that are suitable to them. This is largely emphasized by 53.2% of respondents who have a perception on insurance providers that they don't have products which are designed for low income persons. The existence of such perceptions and attitudes among respondents limits their willingness to uptake insurance products in the informal sector. As Wagstaff, (2009) explains, the insurance must be offered at premiums that are considerably below the actuarially fair price. Given that most employment in low and middle-income countries is informal, governments manage compulsory insurance in the formal sector with limited avenues to cross-

subsidize the informal sector. Thus, health insurance is tax financed, although funding for it may be ring-fenced.

In this study, people in the informal sector have a perception that the process of acquiring scheme to the benefit of the applicant takes a lot of time. This perception affects the enrollment levels and therefor the uptake of health insurance services in the informal sector. As Schneider (2005) explains some people feel dissatisfied with technical processes of the scheme. These included collection of cards, the opening hours of the scheme offices and the location of the scheme. These issues regarding the technical processes also render the scheme unattractive to some people as stated earlier in this discussion. Many insurance schemes operate within weakly defined legal and political systems; and are based on mutual, non-written agreements that are monitored and enforced by members. Sometimes managers often lack the technical capacities to manage an insurance scheme and negotiate with providers for better care.

In this study, 45.6% of the people in the informal sector have had negative experience with the health insurance providers. The informal sector business persons have limited confidence in services of health insurance institutions and are not optimistic about the reliability and credibility of health insurance services providers and this has greatly affected their decision making process in the uptake of health insurance services.

In the study, it was revealed that have a negative attitude towards health insurance as many take it as unreliable business. The explanation for the above negative attitude could be that many people in the informal sector. Many consider using such money for business rather than putting it in insurance scheme. Therefore people with negative attitude towards insurance do not want to take up the health insurance services. It was also revealed that some insurance policy sales

personnel are rude and cannot effectively convince clients. All these attitude issues significantly contribute to low uptake of health insurance services in the informal sector.

However from the majority 64.7% of respondents don't agree that health insurance companies don't give quality services. To many respondents health insurance companies offer quality services that and this should improve the uptake of health insurance services in the informal sector.

4.6 Financial barriers to health insurance services uptake in the informal sector

The study examined financial barriers to health insurance services uptake in the informal sector. The variable financial barrier was looked at in regard to premium prices, employment status, and economic status. Respondents were engaged in answering questionnaires and interviews and results are presented below from questionnaires and interview results. Results from questionnaires were computed to obtain frequencies and percentages and findings from the interview are presented in themes and quotation and results are presented below.

Table 7: Items relating financial barriers to the uptake of health insurance services in the informal sector

Financial barriers to health insurance services uptake	SD		D		NS		A		SA		
	F	%	F	%	F	%	F	%	F	%	
The premium payment terms are fixed (not flexible) e.g. annual payments	11	8	15	10.9	57	41.6	21	15.3	33	24.1	3.36
I cannot afford the total costs for health insurance	13	9.5	24	17.5	27	19.7	47	34.3	26	19	3.36
My employment type cannot afford to access insurance services	13	9.5	30	21.9	16	11.7	44	32.1	34	24.8	3.41
My source(s) of income are not stable to support acquisition of health insurance services	20	14.6	28	20.4	23	16.8	39	28.5	27	19.7	3.18
My business earnings cannot support health insurance services	22	16.1	22	16.1	9	6.6	28	20.4	55	40.1	3.50
Payment for renewal of health insurance is high	13	9.5	29	21.5	21	15.3	57	41.6	17	12.4	3.26
I am not formally employed to access insurance	7	5.1	15	10.9	23	16.8	45	32.8	47	34.3	3.80
Don’t have other alternative sources of income	12	8.8	22	16.1	28	20.4	49	35.8	26	19	3.40

The study showed that 39.4% of the respondents either agree or strongly agree that the premium payment terms are fixed (not flexible) e.g. annual payments. 43.3% of the respondents agree or strongly agree that they cannot afford the total costs for health insurance.

Up to 56.9% of the respondents agree or strongly agree that their employment type cannot afford to access insurance services while60.5% of the respondents agree or strongly agree that their business earnings cannot support health insurance services. 48.2% of the respondents agree or strongly agree that their source(s) of income are not stable to support acquisition of health insurance services.

A further 54% of the respondents agree that payment for renewal of health insurance is high while 67.1% of the respondents agree or strongly agree that they are not formally employed so as to access health insurance services. 54.8% of the respondents agree or strongly agree that they don't have other alternative sources of income.

Some of the responses to the open ended items related to the financial barriers to the uptake of health insurance services in the questionnaire are presented below. These represent the views of many informal business persons that participated in this study.

"….the fixed premium is a lot for some informal population…and due to the increase in the dollar rate, the insurance services become rather a burden to business…"

".... most of us have unstable incomes for example I am not sure of how much I may earn next month how do I enroll…. people even have financial problems to the extent of not being able to feeding their families and then how insurance…."

4.6.1 Correlation between the financial barriers and health insurance services uptake in the informal sector

Results from a correlation analysis between the financial barriers and health insurance services uptake in the informal sector are presented in the table below.

Table 8: Correlation between the financial barriers and the uptake of health insurance services in the informal sector

Correlations			
		Uptake	Financial Barriers
Uptake	Spearman's Rho Correlation	1	.473**
	Sig. (2-tailed)		.000
	N	137	137
Financial Barriers	Spearman's Rho Correlation	.473**	1
	Sig. (2-tailed)	.000	
	N	137	137
** Correlation is significant at the 0.01 level (2-tailed).			

Table 8 shows that the uptake of health insurance services and the financial barriers have a positive significant correlation, $r(135) = 0.473$, $p \leq 0.00$. This implies that in a situation where people in the informal sector can afford the premium prices and have enough knowledge on

them, their employment status supports them for uptake and their economic status is favorable there is likelihood that uptake of health insurance services will significantly improve among the informal sector people.

According to Toonen et al (2009) financial costs are one of the potential barriers to access to health care. Sinha et al, (2005) further argues that the cost of health insurance premiums deters some members from taking up health insurance schemes. In the study, it was found out that the premium required is a bit big and this affects the affordability of most participants in the informal sector to uptake insurance services. Also, the respondents were not sure of the flexibility of premium payment terms in the health insurance scheme process. The above together with lack of information on the flexibility of premiums and how they work greatly impacts on the uptake of health insurance services

This implies that the premium charged in the health insurance is a bit high and this affects their insurance uptake decision. The severity of non-price barriers can also play a major role in health insurance acquisition, which results in variation of the impact of health insurance on healthcare utilization for some population groups.

The uptake of health insurance schemes is largely affected by credit flows within networks of families and friends (Cox, et al. 2008). In this study, it was found out that, most people in the informal sector have no salary and even those who have earn meager and therefore it becomes hard to them to join insurance services. Therefore financial costs are not affordable to many in the informal sector to afford health insurance process. People that have relatively low income earning jobs are most likely not to take up health insurance services.

Health insurance premiums are paid on fixed terms. This also hinders people in the informal sector to take up health insurance services because the flow of their income may not match the terms of payment. The income of the informal sector is not consistent. There are profitable and non-profitable seasons when the financial conditions are not stable, and the prices are high, in each sector, it is difficult to go for health insurance services. It was found out that the cost of health insurance services limit low income earners from joining insurance services. Hence people have little savings and cannot risk giving them out to the company for health insurance uptake hence low uptake of health insurance services some changes come when the business profits decline. This implies that the uptake of health insurance services is affected by the financial challenges faced by people in the informal sector. People in the informal sector have limited resources for immediate needs that need to be fulfilled and hence cannot opt to enroll for health insurance.

4.7. Multiple regression between knowledge barriers, attitude barriers and financial barriers to the uptake of health insurance services

To establish how the three variables of knowledge barriers, attitude barriers and financial barriers influence uptake of insurance services in the informal sector, a regression analysis was done and findings are presented in the table below.

Table 9: Regression analysis between knowledge barriers, attitude barriers and financial barriers and the uptake of health insurance in the informal sector

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.802[a]	.643	.635	.30042

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	.501	.083		6.051	.000
	Attitude barriers	.041	.027	.116	1.502	.135
	Financial barriers	.105	.027	.220	3.940	.000
	Knowledge barriers	.226	.030	.602	7.530	.000

a. Dependent Variable: uptake of health insurance services

b. Predictors: (Constant), Knowledge , financial, attitude barriers

Source: Primary data

Results from the table above show how knowledge barriers, attitude barriers and financial barriers can predict uptake of health insurance services in the informal sector. These variables

can explain 64.3% of the variance in the uptake of health insurance services among the informal sector(Adjusted r square =.635).

This implies that any change on the three barriers would lead to 64.3% chance change in uptake of health insurance services among the informal sector business persons.

The most influential predictor of insurance services uptake was knowledge barrier (Beta = .602) with a relative importance of 7.530 (in t-test). This implies that the more knowledge about health insurance services the people in the informal sector have the more they are likely to take on the services and vice versa. Also financial barrier (Beta=.220) is a significant predictor of insurance uptake with a relative importance of 3.940 (in t-test).

This implies that if the informal sector people have the financial support and capacity they are more likely to take on health insurance services of course backed up by availability of information on insurance to them.

Attitude barriers in this model do not significantly influence the uptake of health insurance services among the informal sector (Beta=.116, p=.135) meaning that the presence of attitudes do not necessarily influence the uptake of health insurance services among the informal sector business people.

4.8 Conclusion

The study concluded that lack of information and the unstable financial status contribute individually and collectively to the low uptake of health insurance services in the informal sector.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The study examined the relationship of knowledge, financial and attitude barriers to the uptake of health insurance services uptake in the informal sector in the Central Division of Kampala city.

This chapter presents the summary of findings, conclusions and recommendations of the study and these are presented according to the findings in objective in chapter four.

5.2 Summary of Findings.

In the study, it was revealed that there is a challenge of a knowledge gap as majority 75% of respondents agreed that no one has endeavored to sensitize the informal sector people about health insurance. There is a strong significant correlation between knowledge and uptake of health insurance services, $r(135) = .773$ $p \leq 0.00$.

This implies that no stakeholder in the health insurance sector has endeavored to educate and provide enough information on the importance of up taking health insurance and this largely contributes low uptake of health insurance especially in the informal sector most people in the informal sector lack adequate information on health insurance and how it works. This comes from the fact that none of the players in the insurance sector has endeavored to reach the informal sector and sensitize them on the various products offered by the insurance industry.

This therefore implies that if people have no knowledge about a service, they will not have interest in using it or paying for it and this has largely reduced the levels of health insurance

uptake in the informal sector. If the different players in the industry endeavored to reach the informal sector members and provide them with increased and improved knowledge the uptake would also be improved. This explains the fact that the uptake levels of health insurance services are defined by the level knowledge about insurance in the sector there is great lack of lack of information that can be provided to the people in the informal sector so as to find particular products which may be affordable to them for uptake.

Also most do not know about health insurance services, their benefits and costs since there is lack of communication about health insurance in the informal sector and this reduces their chances and level of uptake of health insurance services in the informal sector. From the majority 53.5% of the respondents it was agreed that health insurance services are perceived as expensive and designed for those in formal employment and designed for in the corporate world. This perception however affects the uptake of health insurance services especially among the informal sector members.

In the study, it was revealed that there is a negative attitude that health insurance is only meant for the rich and those in formal employment. The study also showed a significant correlation between attitude barriers and the uptake of health insurance services, $r\ (135) = 0.682$, $p \leq 0.00$. This implies that the informal sector people have a belief that health insurance is expensive for low income earners and they cannot afford to access such services. People have an attitude that most people in the informal sector cannot afford the premium of insurance.

Some informal sector business persons believe that health insurance is designed for a particular group affects and explains the lower uptake of health insurance services. The negative attitudes largely determine whether a person in the informal sector is likely or not likely to uptake the health insurance services.

In the study, it was found out that the premium required is a bit big and this affects the affordability of most participants in the informal sector to uptake insurance services. There was a significant correlation between financial barriers and the uptake of health insurance services, r (135)=0.473 p≤0.00.

The premium charged in the health insurance is considered high and this affects their health insurance uptake decision. Most people in the informal sector have no salary and even those who have earn meager and therefore it becomes hard to them to join insurance services. Therefore financial costs are not affordable or flexible enough to many in the health insurance process. People that have relatively low income earning jobs in most cases will not take up health insurance services.

Enrolling for health insurance is putting their finances at risk because every time one has to pay them. Also it was found out that unstable income in the business sector stops from accessing health insurance services. When the insurance is bankrupt, it cannot enroll for the exercise in the field. Financial barriers in a way that health insurance services are expensive. A low earning income person cannot involve herself. Due to their fixed payments, it stops people from joining health insurance services. Some changes come when the business profits decline. Most people earn salaries which are not substantial. Low income earners may be hindered from up taking health insurance services.

A multiple regression analysis of knowledge, attitude and financial barriers showed that the three variables explain 64.3% of the variance in the uptake of health insurance services (adjusted r = .635). Knowledge barriers were the most influential predictor of health insurance services uptake

(Beta= .602) followed by financial barriers (Beta= .220). Attitude barriers had no significant influence (Beta=.116)

5.3 Conclusions

From the findings of the study the following conclusions were reached;

There is a great challenge of knowledge gap among the informal sector business to uptake health insurance services. Majority in the informal businesses do not have much information on the different products offered by the insurance companies, they do not have information on the different premiums that one can pay for an insurance service and they have limited information on the various benefits or challenges that may be faced when one is on an insurance scheme. This largely contributes to low uptake of health insurance services among the informal sector members.

In the informal sector majority respondents have negative attitude towards the health insurance scheme, most people think it's for the rich, others think it's for the formally employed and others take it as a waste of money since some consider themselves not sickly so they don't see why they should put money in such a venture and this largely affects the uptake of health insurance among the informal sector members. Others think insurance companies are here to still from them hence do not find it safe to invest in health insurance schemes. This was however not significant in the multiple regression analysis. The main significant barriers were knowledge and financial.

The informal sector faces a great financial challenge in the uptake of health insurance services. Majority people in the informal sector say they don't have a fixed salary which they may use to acquire insurance health services but simply rely on the unstable business environment so they

cannot risk enter insurance with constant demand of renewal for the services. This significantly limits the uptake of health insurance services in the informal sector.

5.4 Recommendations

From the findings of the study, the following recommendations were made:

There is need to improve on information availability to the informal sector people. The information provision must cover the different services provided by insurance companies, the different premiums, the benefits from insurance schemes and easiness in the payment and service acquisition. This can be done by using the local people to educate their fellows on health insurance services, advertising to the general public, by printing their information in all languages and in different formats.

They may also go and teach people in the business sector the importance of health insurance. There can also provide enough information through promotions on health insurance, organize the study seminars in the community, use of the media like televisions, radios to sensitize the people about it. Sending different sales persons around the communities to explain to the people the benefits of health insurance and providing some free sample health insurance policies to a few individuals in the informal sector. Such measures may help to increase information among the informal sector and this will increase awareness to improve uptake of health insurance services.

There is need to clear the negative attitude towards health insurance, which most think it's for the rich and those with formal employment. This can be done by reaching out to people such as business areas, and areas of social interactions physically and explaining the benefits and importance health insurance among them.

Through involving the representatives in the informal sector in the policy formulation of the health insurance procedures so as to change their attitudes and such representatives can help

explain to others the importance of health insurance. Sensitize the informal sector people on the dangers of not joining health insurance services through workshops or door to door awareness with flyers in local languages, plays, talk shows on a regular basis.

There is need to address the financial barriers among the informal sector members. This can largely be done by reaching to the low income earners with relatively low premiums that are realistic and affordable to them with reduced costs for everyone to afford. Insurance companies should talk about the disadvantages of pocket payment in favor of insurance and teaching more about the benefits of health insurance this may be done through adverts on radio, through workshops, church events and other means that friendly to everyone in local languages. This will enable many to understand the importance of health insurance and be able to enroll for the health insurance services. Flexible payment terms designed to address the unstable incomes of the private sector will also help in improving the uptake of the services.

5.5 Areas for further research

1. Examine the role of government policies in the uptake health insurance services by the informal sector in Uganda.
2. Examine how insurance company partnerships with financial institutions improves uptake of health insurance services in the informal sector.

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APPENDIX I: QUESTIONNAIRE FOR RESPONDENTS.

Questionnaire number.....

Dear respondent,

My name is Darlington Muhwezi, a student of Master of Business Administration at Uganda Martyrs University. I am requesting you to fill this questionnaire, which is aimed at collecting data on the barriers to the uptake of health insurance services in the informal sector in Central Division, Kampala City.

You have been selected to be one of the respondents in this study. The information provided will be treated with strict confidentiality and will not be used for any other purpose except for academic purposes. The researcher will ensure your anonymity and confidentiality. Thank you very much for your cooperation.

SECTION A

Tick the appropriate answer

1. What is your gender?

Male ☐ Female ☐

2. What is the highest level of education you have attained?

Primary level ☐ Ordinary level ☐ Advanced level ☐ Diploma ☐ Degree ☐

Master's degree, PhD ☐ Others (specify)…. ☐

3. What is your age group?

Below 20 years ☐ 20-30years ☐ 31-40years ☐ 41-50years ☐ 51 years and above ☐

For the following questions please tick the number of your choice:

Key

1. **Strongly Disagree (SD) 2. Disagree (D) 3. Not Sure (NS) 4. Agree (A) 5. Strongly agree (SA)**

SECTION B

Knowledge barriers to the uptake of health insurance services in the informal sector

		SD	**D**	**NS**	**A**	**SA**
1.	No one has come to me to sensitize me about health insurance	**1**	**2**	**3**	**4**	**5**
2.	I don't know about insurance premiums, payments and how they work	**1**	**2**	**3**	**4**	**5**
3.	I don't have knowledge on the different indirect and direct insurance benefits packages	**1**	**2**	**3**	**4**	**5**
4.	I don't know about the medical services that are covered under health insurance	**1**	**2**	**3**	**4**	**5**
5.	I don't know where to get information on health insurance services	**1**	**2**	**3**	**4**	**5**
6.	I don't know the key challenges associated with health	**1**	**2**	**3**	**4**	**5**

	insurance policies					
7.	I do not know about the exclusions associated with health insurance	**1**	**2**	**3**	**4**	**5**
8.	I don't have knowledge on health insurance risk pooling	**1**	**2**	**3**	**4**	**5**
9.	I don't have knowledge on where to get an effective and efficient health insurance service provider	**1**	**2**	**3**	**4**	**5**
10.	I don't have knowledge on affordable insurance products	**1**	**2**	**3**	**4**	**5**

In your own opinion give your view on howknowledge is a barrier to the uptake of health insurance services in the informal sector.

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How can the industry players better sensitize the informal sector business community about the importance of health insurance?

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In your opinion, how would the level of education attained by an individual affect the uptake of health insurance services?

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SECTION C

Attitude Barriers to the uptake of health insurance services in the informal sector

		SD	**D**	**NS**	**A**	**SA**
1	Health insurance is expensive and designed and those in formal employment only	**1**	**2**	**3**	**4**	**5**
2.	I don't trust the promises given by health insurance service providers	**1**	**2**	**3**	**4**	**5**
3.	Access to Health insurance services is a complex processes	**1**	**2**	**3**	**4**	**5**
4.	There are no flexible premium payment options	**1**	**2**	**3**	**4**	**5**
5.	Takes a lot of time and procedure to enroll	**1**	**2**	**3**	**4**	**5**
6.	Products are not designed for the low income persons	**1**	**2**	**3**	**4**	**5**
7.	Insurance is administered by fraudulent corporations	**1**	**2**	**3**	**4**	**5**
8.	Negative experience with agents who misleadclients	**1**	**2**	**3**	**4**	**5**
9.	Health insurance providers are inconveniently located	**1**	**2**	**3**	**4**	**5**
10	Insurance health companies don't give quality services	**1**	**2**	**3**	**4**	**5**
11.	Insurance is source of bad luck	**1**	**2**	**3**	**4**	**5**

In your own opinion explain how attitude barriers influence the uptake of insurance services in the informal sector

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Why would you as an informal business person not take up health insurance services?

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SECTION D

Financial Barriers to the uptake of health insurance services in the informal sector.

		SD	**D**	**NS**	**A**	**SA**
1.	The premium payment terms are fixed (not flexible)	**1**	**2**	**3**	**4**	**5**
2.	I cannot afford the total costs for health insurance	**1**	**2**	**3**	**4**	**5**
3.	My employment cannot afford me insurance services	**1**	**2**	**3**	**4**	**5**
4.	My source of income are not stable to support acquisition of health insurance services	**1**	**2**	**3**	**4**	**5**
5.	My business earnings cannot support health insurance services	**1**	**2**	**3**	**4**	**5**
6.	Payment for renewal of health insurance is high	**1**	**2**	**3**	**4**	**5**
7.	I am not formally employed to access insurance	**1**	**2**	**3**	**4**	**5**
8.	My occupation type can't allow me take up insurance	**1**	**2**	**3**	**4**	**5**
9.	Don't have other alternative sources of income	**1**	**2**	**3**	**4**	**5**

Give your view on how financial barriers affect uptake of insurance services in the informal sector

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What advice would you give health insurance companies to increase health insurance uptake in the informal sector?

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